JAMES J. DONELON
COMMISSIONER OF INSURANCE
STATE OF LOUISIANA

P.O. Box 94214
Baton Rouge, Louisiana 70804-9214
Phone (225) 342-5900
Fax (225) 342-3078
http://www.ldi.state.la.us

INDEPENDENT REVIEW ORGANIZATION CERTIFICATION APPLICATION FORM

GENERAL INSTRUCTIONS

This packet is designed to assist the individual preparing the application in complying with our requirements and procedures. The forms and procedures of the application process are designed to facilitate our review of the application. Therefore, it is extremely important that all applicants comply fully with the instructions and requirements set forth in this packet.

All communication should be directed to:

Louisiana Department of Insurance
Company Licensing Division
P.O. Box 94214
Baton Rouge, LA 70804-9214
Phone: (225) 219-4318
Fax: (225) 342-7401
E-Mail: mboutwell@ldi.state.la.us

While our Department will be happy to assist you and answer any questions you may have, we ask that you thoroughly review all instructions and forms before contacting us.

1) **All submittals in association with this application must reach us via the United States Postal Service or a carrier with interstate business. Hand delivery is not acceptable and any information arriving in this manner will be returned without review. In addition, all correspondence must be sent to the attention of the Company Licensing Division to assure prompt receipt and handling.**

2) **Submit only a fully completed application. Submittal of a partially completed application will cause processing delays and may result in disapproval.**

3) **Do not alter the forms contained in this packet. If you feel the requirements do not apply to your situation, notify us. We will supply the proper form, if appropriate, and/or answer any questions you have about the forms.**

4) All original items submitted become the property of the Louisiana Department of Insurance and <u>will not be returned</u>.

5) All certified documents required in the application must be dated within ninety (90) days of submittal of the application.

6) All entries in the application forms must be typed or printed. Illegible entries or responses will be considered incomplete and may result in the disapproval of the application.

7) When designating a contact person for the application process, please remember that our staff will communicate only with that individual. The application process is considered confidential and will not be discussed with any person other than the named contact person. We must be notified in writing of any change in the contact person.

8) We must be notified of any changes in the applicant or the information submitted in association with this application that occurs while the application is under review. This includes changes in officers and directors and changes in address or domicile. Failure to notify us of such changes may result in disapproval of the application.

9) If, for some reason, an item that would otherwise be required is not available, a written explanation must be supplied upon submission.

10) Each exhibit requested in Section 5 of the application must be clearly labeled and dated.

11) It is the responsibility of the applicant to insure that none of the responses and submittals in association with this application conflict with the information filed with the domiciliary state. Conflicting information will result in the disapproval of the application.

REGISTRATION WITH THE LOUISIANA SECRETARY OF STATE

Submitting this application to the Louisiana Department of Insurance does not in any way dismiss a corporation from the requirements of registration with the Louisiana Secretary of State. It is the responsibility of the corporation to contact that Office and make whatever arrangements may be necessary. The address and telephone number are given below.

Louisiana Secretary of State
Corporations Division
P.O. Box 94215
Baton Rouge, LA 70804-9215
(225) 925-4704

SPECIAL INSTRUCTIONS FOR NOTARIZATION PAGE

The signatures that appear on the final page of the application are determined by the legal structure of the applicant. Below are the expected variations and the instructions for who should sign the application in each case.

IF THE APPLICANT IS A(N)....	THE APPLICATION SHOULD BE SIGNED BY...
Individual	the applicant
Corporation	the president and secretary
Association	the president and secretary
Partnership	two partners
Trust	two trustees
Any other	contact the Department for instructions

COMMON QUESTIONS

The following are some of the most commonly asked questions regarding the application package and process.

Q: Where can I find the laws and regulations governing medical necessity review organizations and independent review organizations in Louisiana?

A: The laws governing medical necessity review organizations and independent review organizations can be found in Chapter 7 of Title 22 of the Louisiana Revised Statutes (LRS 22:3070 et seq.). For your convenience, a copy of the statutes and rules are available on the Department of Insurance's web page at www.ldi.state.la.us.

Q: What is the time frame for the review of an application?

A: This Department reviews all applications as soon after submittal as possible. The review process can be expected to take from sixty (60) to ninety (90) days from receipt of a complete application. Please take this time frame into account when considering deadlines and operation schedules for the applicant.

Q: Can the forms in the application packet be recreated on a word processor for completion by the applicant?

A: No. The forms in this packet are designed for ease of recognition by our staff and, in many cases, in strict compliance with statutory wording requirements. Therefore, any changes in the format or wording of the forms will cause delays in the review and may lead to the disapproval of the application. The forms are, however, available in MS Word format via electronic mail upon request.

Q: Can we meet with the Department for a preliminary review of our application prior to submission?

A: Yes. Our staff will be happy to meet with representatives of the applicant to review the application before it is actually submitted. It should be noted, however, that this courtesy review is to help assure completeness only and our Division will not issue a preliminary approval or disapproval of the application prior to submission. Any application sent to this Office via U.S. Mail will be considered submitted for review and will not be eligible for a pre-review. You may make an appointment for preliminary review by contacting the Company Licensing Division of the Louisiana Department of Insurance. Preliminary reviews will be performed only with an appointment.

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APPLICATION FOR CERTIFICATION AS AN INDEPENDENT REVIEW ORGANIZATION IN THE STATE OF LOUISIANA

General Information (Type or Print)

APPLICANT NAME: _____

TRADE NAME: _____

FEI OR SOCIAL SECURITY NO. _____

DOMICILE: _____

HOME OFFICE ADDRESS: _____

_____

_____

CONTACT NAME†: _____

CONTACT TITLE: _____

CONTACT ADDRESS: _____

_____

_____

PHONE: _____ **FACSIMILE:** _____

CONTACT E-MAIL: _____

† This Office will only communicate with the named contact person.

SECTION 2 - INTERROGATORIES

All of the following questions must be answered for every applicant. ATTACH A FULL EXPLANATION FOR ANY "YES" ANSWERS

1) Has the applicant ever had an application denied by any state regulatory authority?	☐ **YES**	☐ **NO**
2) Has the applicant ever been subject to any regulatory action including cease and desist orders, revocation of license or similar actions by any state?	☐ **YES**	☐ **NO**
3) Has the applicant ever changed its name?	☐ **YES**	☐ **NO**
4) Within the last five years, has the applicant merged or consolidated with any other entity?	☐ **YES**	☐ **NO**
5) Within the last five years, has the applicant undergone a change in ownership of five percent or more?	☐ **YES**	☐ **NO**
6) Is the applicant presently negotiating or inviting negotiations or acting as party to a counter letter which would result in a merger or consolidation with any other entity or which would result in a change of ownership of five percent or more?	☐ **YES**	☐ **NO**
7) Does the applicant contemplate a change in management or any transaction which would normally result in a change of management within the foreseeable future?	☐ **YES**	☐ **NO**
8) Is the applicant owned, operated or controlled, directly or indirectly, by any other state or province, district, territory or nation or any governmental subdivision or agency?	☐ **YES**	☐ **NO**
9) Is the applicant a plaintiff or defendant or subject in any legal action? If yes, provide a full explanation of the allegations and circumstances of the suit as well as a current status and jurisdiction of the suit including the status of any settlement negotiations.	☐ **YES**	☐ **NO**
10) Does the applicant, any officer or director of the applicant, any person owning five percent or more of the applicant or any clinical peer reviewer employed by the applicant have any material professional, familial or financial interest in any MNRO for which the applicant will be conducting external reviews?	☐ **YES**	☐ **NO**
11) Does the applicant own or control any other health insurance issuer, health benefit plan, a national, state or local trade association of health benefit plans, or a national, state, or local trade association of heath care providers?	☐ **YES**	☐ **NO**
12) Is the applicant a party to any agreement or understanding with any insurer in which the effect of the agreement is to make the amount of the applicant's commission, fees, or charges contingent upon savings realized in the adjustment, settlement, and payment of losses covered by the insurer's obligations?	☐ **YES**	☐ **NO**
13) Does any clinical peer reviewer employed by or contracted with the applicant have a history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions by any hospital, governmental agency or unit or any regulatory body?	☐ **YES**	☐ **NO**
14) Has any person who is presently an officer, director or owner of five percent or more of the applicant ever been convicted of or pleaded guilty or nolo contendere in any jurisdiction to a felony or misdemeanor other than minor traffic violations?	☐ **YES**	☐ **NO**

SECTION 3 - LIST OF MANAGEMENT

Below give a complete list of all persons responsible for the conduct of affairs of the applicant. This list should include all officers, all directors, all trustees, all executive committee members and all person(s) owning, directly or indirectly, five percent or more of the applicant and all other persons who exercise control or influence over the affairs of the applicant.

Name	Position	Ownership Percentage

SECTION 4 - LIST OF INDIVIDUALS MAKING ADVERSE MEDICAL DECISIONS

Below give the name, resident address, medical license number, state of issuance of the license and specialty of the medical director(s) of the applicant and any other individuals designated to make adverse medical decisions.

NAME:		**LICENSE#:**		**STATE OF ISSUANCE:**			
STREET:		**CITY:**		**STATE:**		**ZIP:**	
PRIMARY SPECIALTY:		**DATE OF SPECIALTY CERTIFICATION EXPIRATION:**					
SUB-SPECIALTY:		**DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:**					
NAME:		**LICENSE#:**		**STATE OF ISSUANCE:**			
STREET:		**CITY:**		**STATE:**		**ZIP:**	
PRIMARY SPECIALTY:		**DATE OF SPECIALTY CERTIFICATION EXPIRATION:**					
SUB-SPECIALTY:		**DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:**					
NAME:		**LICENSE#:**		**STATE OF ISSUANCE:**			
STREET:		**CITY:**		**STATE:**		**ZIP:**	
PRIMARY SPECIALTY:		**DATE OF SPECIALTY CERTIFICATION EXPIRATION:**					
SUB-SPECIALTY:		**DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:**					
NAME:		**LICENSE#:**		**STATE OF ISSUANCE:**			
STREET:		**CITY:**		**STATE:**		**ZIP:**	
PRIMARY SPECIALTY:		**DATE OF SPECIALTY CERTIFICATION EXPIRATION:**					
SUB-SPECIALTY:		**DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:**					
NAME:		**LICENSE#:**		**STATE OF ISSUANCE:**			
STREET:		**CITY:**		**STATE:**		**ZIP:**	
PRIMARY SPECIALTY:		**DATE OF SPECIALTY CERTIFICATION EXPIRATION:**					
SUB-SPECIALTY:		**DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:**					
NAME:		**LICENSE#:**		**STATE OF ISSUANCE:**			
STREET:		**CITY:**		**STATE:**		**ZIP:**	
PRIMARY SPECIALTY:		**DATE OF SPECIALTY CERTIFICATION EXPIRATION:**					
SUB-SPECIALTY:		**DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:**					
NAME:		**LICENSE#:**		**STATE OF ISSUANCE:**			
STREET:		**CITY:**		**STATE:**		**ZIP:**	
PRIMARY SPECIALTY:		**DATE OF SPECIALTY CERTIFICATION EXPIRATION:**					
SUB-SPECIALTY:		**DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:**					

SECTION 5 - EXHIBITS

1) EXHIBIT A - COPY OF THE ARTICLES OF INCORPORATION, ARTICLES OF ASSOCIATION, PARTNERSHIP AGREEMENT OR OTHER SUCH ORGANIZATIONAL DOCUMENTS AND ALL AMENDMENTS THERETO of the applicant certified by the proper domiciliary official. The certification must be original and dated within ninety days of submission.

2) EXHIBIT B - COPY OF THE BY-LAWS, RULES, REGULATIONS OR SIMILAR DOCUMENT OF THE APPLICANT certified as true and correct by the secretary of the applicant. The certification must be original and dated within ninety days of submission.

3) EXHIBIT C - TRADE NAME CERTIFICATE issued by the Secretary of State of Louisiana. This item must be supplied by any applicant that will be utilizing a trade name in Louisiana.

4) EXHIBIT D – PLAN OF OPERATION. A general description of the operation of the IRO, which includes a statement that the IRO does not engage in the practice of medicine or acts to impinge or encumber the independent medical judgment of treating physicians or health care providers. The plan must also address the following;

- **Describe your written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process that include, at a minimum, the following:**

  (a) Procedures to ensure that external reviews are conducted within the specified time frames and that required notices are provided in a timely manner.
  (b) Procedures to ensure the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.
  (c) Procedures to ensure the confidentiality of medical and treatment records and clinical review criteria.
  (d) Procedures to ensure that any individual employed by or under contract with the independent review organization adheres to the requirements of this Chapter.

- **Describe your quality assurance program.**
- **State whether or not you have a toll-free telephone service to receive information related to external reviews on a twenty-four-hour-a-day, seven-day-a-week basis that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.**
- **State whether or not any clinical peer reviewer assigned by you to conduct external reviews is a physician or other appropriate health care provider that meets the following minimum qualifications:**
  (a) Is an expert in the treatment of the covered person's medical condition that is the subject of the external review.

(b) Is knowledgeable about the recommended health care service or treatment through actual clinical experience that may be based on either of the following:

i. The period of time spent actually treating patients with the same or similar medical condition of the covered person,

ii. The period of time that has elapsed between the clinical experience and the present.

(c) Holds a nonrestricted license in a state of the United States and, in the case of a physician, has a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(d) Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body, that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

- **State whether or not the applicant owns, controls, is a subsidiary of, in any way owned or controlled by, or exercises control with a health insurance issuer, health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.**
- **Do you or the clinical peer reviewer assigned by you to conduct the external review have a material professional, familial, or financial interest with any of the following:**

(a) The MNRO that is the subject of the external review.

(b) Any officer, director, or management employee of the MNRO that is the subject of the external review.

(c) The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review.

(d) The facility at which the recommended health care service or treatment would be provided.

(e) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(f) The covered person who is the subject of the external review.

5) EXHIBIT E - BIOGRAPHICAL AFFIDAVITS for all persons responsible for the conduct of affairs of the applicant. This shall include all officers, directors, partners (in the case of a partnership), trustees, executive committee members and any person who owns, directly or indirectly, five percent or more of the applicant and any other person who exercises control or influence over the affairs of the applicant and all individuals designed to make adverse medical necessity determinations. Only the most current version of the National Association of Insurance Commissioners biographical affidavits is acceptable. The form can be obtained at our web site (www.ldi.state.la.us).

6) EXHIBIT F – COPY OF THE FORMS OF ALL CONTRACTS in use or to be used by the applicant with medical necessity review organizations for making independent external reviews of the decisions of the organizations

SECTION 6 - GENERAL INFORMATION

1) Below provide the physical address of the principal place of business where the applicant will be operating.

_____

_____

_____

_____

2) Give the name, address, telephone number and e-mail address of the primary contact person with whom this Department should communicate after the licensing process is completed.

_____

_____

_____

_____

Phone_____**E-mail**_____

3) Give the name, address, telephone number and e-mail address of the contact person and division to whom consumer complaints should be directed.

_____

_____

_____

_____

Phone_____**E-mail**_____

4) Give the name, address, license number, state of issuance and the specialty of the medical director of the applicant.

_____

_____

_____

_____

License Number_____ **State of Issuance**_____

Specialty _____

5) Give the toll-free number established by the applicant to receive information related to external reviews.

_____

6) If available, give the URL or World Wide Web address of the applicant.

_____

NOTARIZATION

STATE OF _____

COUNTY OR PARISH OF _____

BEFORE ME, the undersigned authority, personally appeared _____

and _____ **who, after being duly sworn, did depose and say that all information contained in this application and all attachments thereto is, to the best of his knowledge, true, complete and correct.**

_____ _____

Witness' Signature **Signature of Applicant or Authorized Representative**

_____ _____

Witness' Printed Name **Printed Name and Title of Authorized Representative**

_____ _____

Witness' Signature **Signature of Authorized Representative of Applicant**

_____ _____

Witness' Printed Name **Printed Name and Title of Authorized Representative**

SWORN TO and subscribed before me this _____ **day of** _____**, 20**___.

_____

Notary Public's Signature

_____

Notary Public's Printed Name

My Commission Expires_____.